Grantee: New York EMA - H89HA00015

FY2013 Part A Implementation Plan for Progress Report

Part A Award (including carryover): $ 95,351,619

Part A Programs (including carryover): $ 83,675,378

Service Category: AIDS Drug Assistance Program (ADAP) Treatments				**Planning Council Allocation:**	**$8,796,739**
Service Priority: 1				**Part A Core Medical**	
Service Goal: Improve health outcomes of uninsured and underinsured PLWHA.				**Comprehensive Plan: Goal 3: Promote optimal management of HIV infection. Goal 4: Reduce HIV/AIDS health disparities.**	
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Increase access to medications through New York State ADAP for the treatment of HIV/AIDS and opportunistic infections.	One prescription claim	797	25,194	3/1/13 - 2/28/14	$ 11,616,449

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Improving access to prescribed HIV/AIDS medications. Indicator: Increase in the percentage of clients receiving ARV treatment to 90% of clients for whom ARV is indicated.

#2 Outcome: Slowing/preventing disease progression in HIV+ clients. Indicator: Increase in the percentage of clients with improved or stable CD4 counts to 85% of clients with 2 or more CD4 counts during the measurement year.

Service Category: Outpatient/Ambulatory Health Services				**Planning Council Allocation:**	**$5,537,339**
Service Priority: 2				**Part A Core Medical**	
Service Goal: Improve health outcomes of PLWHA.				**Comprehensive Plan: Goal 3: Promote optimal management of HIV infection.**	
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Increase access to HIV primary and specialty care in various clinical settings by reimbursing service providers through the NYS HIV Uninsured Care Program.	One medical visit claim reimbursed by NYS HIV Uninsured Care Program - ADAP Plus	3,591	41,121	3/1/13 - 2/28/14	$ 5,483,675

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients. Indicator: Increase in the percentage of clients retained in care (defined as having two or more HIV medical visits at least 3 months apart in the measurement year) to 80% of clients served and enrolled for most or all of the measurement year.

#2 Outcome: Slowing/preventing disease progression in HIV+ clients. Indicator: Increase in the percentage of clients with improved or stable CD4 counts to 85% of clients with 2 or more CD4 counts during the measurement year.

Service Category: Medical Case Management (including Treatment Adherence)				Planning Council Allocation:	$18,887,184
Service Priority: 5				Part A Core Medical	
Service Goal: Ensure that PLWHA are promptly linked to medical services at time of diagnosis and are provided with all support needed to access lifelong, regular health care. Reduce premature and excess morbidity and mortality by ensuring engagement in primary care and other HIV related care.				Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 3: Promote optimal management of HIV infection. Goal 4: Reduce HIV/AIDS health disparities.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Ensure that PLWHAs are assisted with linkage to and maintenance in primary medical care.	One appointment for intake, assessment, treatment planning or follow-up	4,291	126,911	3/1/13 - 2/28/14	$ 15,645,449
	Linkage to primary care for homeless individuals	270	275	3/1/13 - 2/28/14	$ 34,519
b. Support delivery of primary care to enrolled PLWHA by facilitating adherence to scheduled appointments.	One accompaniment to appointment by patient navigator	1,369	3,707	3/1/13 - 2/28/14	$ 465,317
c. Provide individualized health promotion and adherence support including interdisciplinary medication management support.	One treatment adherence education, coaching, health promotion and/or Directly Observed Therapy visit	932	26,499	3/1/13 - 2/28/14	$ 3,065,520
d. Train medical case management staff in service and health promotion protocols.	One staff training session (multi or single-day)	199	11	3/1/13 - 2/28/14	$ 156,292

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients. Indicator: Increase in the percentage of clients retained in care (defined as having two or more HIV medical visits at least 3 months apart in the measurement year) to 80% of clients served and enrolled for most or all of the measurement year.

#2 Outcome: Achieving and maintaining optimal ARV treatment adherence among those on ARVs. Indicator: Among clients receiving antiretroviral (ARV) medications, an increase in the percentage of clients who adhere to their prescribed medication regimen to 80% of those with four months or more of treatment adherence intervention.

Service Category: Mental Health Services				Planning Council Allocation:	$5,318,445
Service Priority: 7				Part A Core Medical	
Service Goal: Optimize the mental health and level of functioning of PLWHA, and improve access to ongoing medical care.				Comprehensive Plan: Goal 3: Promote optimal management of HIV infection. Goal 2: Promote early entry into and continuity of HIV care.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Improve the mental health functioning of PLWHA to help them connect to and remain in HIV primary care.	One mental health session	1,047	10,504	3/1/13 - 2/28/14	$ 2,385,337
	One visit for psychiatric care or medication management, including buprenorphine	392	2,246	3/1/13 - 2/28/14	$ 488,312
	One AOD treatment session	679	9,744	3/1/13 - 2/28/14	$ 2,118,485

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Improving mental health functioning among HIV+ clients with a mental health condition. Indicator: Among clients with a post-baseline assessment using the SF-12v2 health functioning measure, an increase in the percentage of clients with a mental component score >37 on their most recent assessment in the measurement year to 80%.

#2 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients with a mental health condition. Indicator: Increase in the percentage of clients with mental health conditions who are remaining in HIV/AIDS medical care to 75% of clients served and enrolled for most or all of the measurement year.

Service Category: Substance Abuse Services - Outpatient				Planning Council Allocation:	$7,781,331
Service Priority: 8				Part A Core Medical	
Service Goal: Provide accessible harm reduction and substance use services, reduce negative impact of alcohol and drug use, promote access to and maintenance of HIV primary care and improve ARV adherence.				Comprehensive Plan: Goal 2: Promote early entry into care.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Link clients to HIV primary care and support engagement in care.	One medical outreach visit in SRO	684	536	3/1/13 - 2/28/14	$ 47,622
b. Link clients to substance use services based on need and readiness for engagement.	Harm reduction counseling or education sessions	4,601	67,935	3/1/13 - 2/28/14	$ 6,035,766
c. Help clients reduce HIV risk behaviors and reduce substance abuse behaviors.	One low threshold AOD counseling session	1,829	18,953	3/1/13 - 2/28/14	$ 1,683,902

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Appropriately assessing substance use services need and readiness for engagement. Indicator: Increase in the percentage of clients screened through the DAST-10 and AUDIT-C tools within 31 days of enrollment to 90% of clients with a substance use services enrollment start date at least 31 days prior to the end of the measurement year.

#2 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients with a history of substance use. Indicator: Increase in the percentage of clients with addictions who remain in medical care to 75% of clients served and enrolled for most or all of the measurement year.

Service Category: Early Intervention Services				Planning Council Allocation:	$7,527,220
Service Priority: 9				Part A Core Medical	
Service Goal: Reduce the number of HIV+ individuals unaware of their status, and reduce HIV related morbidity and mortality by effectively linking clients to and engaging clients in medical care.				Comprehensive Plan: Goal 1: Increase individuals who are aware of their HIV status. Goal 2: Promote early entry into HIV care.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Provide outreach and HIV testing to clients who are unaware of their status, and effectively link to HIV primary care both those individuals who test positive and those who are known to be HIV+ but not in care.	One successful outreach with HIV rapid test performed or referral made	30531	31973	3/1/13 - 2/28/14	$ 3,998,937
	One successful outreach with HIV test performed or referral made in harm reduction programs	8695	9489	3/1/13 - 2/28/14	$ 1,197,510
	One linkage to medical care	263	264	3/1/13 - 2/28/14	$ 32,720
	One targeted case finding	27246	1979	3/1/13 - 2/28/14	$ 249,749
	One readiness counseling session	1713	2012	3/1/13 - 2/28/14	$ 253,914
	One successful outreach with HIV rapid test performed or referral made in a correctional, field-service, or STD clinic setting	3554	3688	3/1/13 - 2/28/14	$ 465,425
	One linkage to medical care in a correctional, field-service, or STD clinic setting	116	120	3/1/13 - 2/28/14	$ 15,144
	One linkage to medical care for newly diagnosed clients in a correctional, field-service, or STD clinic setting	8	8	3/1/13 - 2/28/14	$ 1,010

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Increasing awareness (diagnosis and notification/counseling) of positive HIV status among those infected. Indicator: Increase in the percentage of PLWH who know their HIV status (measured as receipt of diagnosis) to 70% of those with new confirmatory positive test results during the measurement year.

#2 Outcome: Facilitating access to and engagement in HIV medical care among the newly diagnosed and those previously diagnosed but out of HIV/AIDS medical care. Indicator: Among PLWH who know their status an increase in the percentage successfully linked to HIV/AIDS medical care to 80%.

Service Category: Home and Community-based Health Services			Planning Council Allocation:		$1,171,714
Service Priority: 13			**Part A Core Medical**		
Service Goal: To improve health outcomes of uninsured PLWHA through increased access to home health care services.			**Comprehensive Plan. Goal 3: Promote optimal management of HIV infection.**		
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Provide comprehensive home health care services to uninsured or underinsured PLWHA.	One home care visit	382	6,518	3/1/13 - 2/28/14	1,170,717

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Ensuring regular access to home-based health services for enrolled clients. Indicator: Increase in the percentage of clients receiving at least 1 unit of service per six-month period of program enrollment to 75% of those enrolled for at least six months.

#2 Outcome: Monitoring and ensuring effective clinical management of HIV disease for Home and Community-based Health Service clients. Indicator: Increase in the percentage of clients with improved or stable viral load test results (measured as viral load suppression) to 70% of those with 2 or more viral load tests during the measurement year.

Service Category: Oral Health Care			Planning Council Allocation:		$200,411
Service Priority: 14			**Part A Core Medical**		
Service Goal: To improve health outcomes of uninsured PLWHA through increased access to oral health care services.			**Comprehensive Plan: Goal 3: Promote optimal management of HIV infection.**		
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Provide comprehensive dental care services for uninsured or underinsured PLWHA in Tri-County.	One dental care service	165	1,053	3/1/13 - 2/28/14	199,894

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Ensuring regular receipt of needed oral health care services/treatments. Indicator: Increase in the percentage of clients who are accessing oral health/dental services to 70% of those enrolled for at least six months.

#2 Outcome: Monitoring and ensuring regular engagement in primary medical care for Oral Health Care clients. Indicator: Increase in the percentage of oral health care clients who are remaining in HIV/AIDS medical care to 80% of clients served and enrolled for most or all of the measurement year.

Service Category: Housing Services			Planning Council Allocation:		$8,872,370
Service Priority: 6			**Part A Support**		
Service Goal: Reduce homelessness, and improve housing access for PLWHA. Reduce HIV-related morbidity for homeless or unstably housed PLWHA. Increase access and engagement in medical care for target population.			**Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 4: Reduce HIV/AIDS health disparities.**		
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Provide housing placement assistance and transitional housing for PLWHA who are unstably housed, homeless and in targeted communities so that they can access and remain engaged in HIV primary care.	One transitional housing placement	108	118	3/1/13 - 2/28/13	311,848
b. Placement in permanent housing for those individuals who request it.	One permanent housing placement	292	328	3/1/13 - 2/28/14	871,184
c. Provide emergency rental start-up assistance, short-term rental assistance, and emergency utility payments for PLWHA who are not eligible for any other rental assistance.	One payment for rental and utility assistance	473	3,954	3/1/13 - 2/28/14	7,334,566

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Increasing access to and maintenance of stable housing. Indicator: Increase in the percentage of HIV+ clients in housing services who achieve a stable housing situation as of last assessment to 65% of those re-assessed for housing status during the measurement year and receiving at least six months of housing services prior to that re-assessment.

#2 Outcome: Retaining HIV+ housing services clients in HIV primary care. Indicator: Increase in the percentage of housing services clients who are remaining in HIV/AIDS medical care to 75% of clients served and enrolled for most or all of the measurement year.

Service Category: Food Bank/Home-Delivered Meals			Planning Council Allocation:		$6,075,474
Service Priority: 3			**Part A Support**		
Service Goal: Promote access to and maintenance in HIV medical care, provide nutritious food and/or nutrition services to PLWHA in need and enhance treatment adherence.			**Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 4: Reduce HIV/AIDS health disparities.**		
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Provide nutritional screening and periodic reassessment of nutritional status.	One nutritional screening and assessment visit	5,078	10,230	3/1/13 - 2/28/13	98,317
b. Facilitate access to adequate and appropriate nutrition using home delivered meals, congregate meals, pantry bags, and/or supplemental food vouchers.	One pantry bag	2,157	232,951	3/1/13 - 2/28/14	2,191,933
	One client meal	3,312	362,948	3/1/13 - 2/28/14	3,650,428
	One food voucher	792	13,293	3/1/13 - 2/28/14	219,493
c. Ensure that PLWHAs are engaged in primary care.	One verification of primary care	3,398	5,709	3/1/13 - 2/28/14	53,718
	One linkage to care	1	1	3/1/13 - 2/28/14	9

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Improving access to nutritionally adequate food and ability to acquire food in socially acceptable ways. Indicator: Increase in the percentage of HIV+ clients in food services programs who are not food-insecure as of last assessment to 70% of those re-assessed for food security during the measurement year.

#2 Outcome: Retaining HIV+ food/nutrition services clients in HIV primary care. Indicator: Increase in the percentage of food services clients who are remaining in HIV/AIDS medical care to 85% of clients served and enrolled for most or all of the measurement year.

Service Category: Case Management (non-Medical)				**Planning Council Allocation:**	**$4,781,945**
Service Priority: 4				**Part A Support**	
Service Goal: Provide referral, linkage, and support in accessing necessary medical and social services for people living with HIV to promote access to and maintenance in HIV medical care.				**Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 3: Promote optimal management of HIV infection. Goal 4: Reduce HIV/AIDS health disparities.**	
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Re-establish client engagement with HIV primary care provider upon release from correctional facility.	One visit to assess need and develop discharge plan for inmates	1,384	1,661	3/1/13 - 2/28/13	466,899
	One accompaniment/escort to appointment	2,616	11,873	3/1/13 - 2/28/14	3,337,440
b. Ensure that PLWHAs are assisted with linkage to and maintenance in primary medical care.	One appointment for intake, need assessment, treatment planning or follow-up	333	16,678	3/1/13 - 2/28/14	810,746
	Linkage to medical or social services	0	0	3/1/13 - 2/28/14	0

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Facilitating access to HIV primary care following discharge, for those HIV+ clients without a current connection to HIV primary care in the community. Indicator: Increase in the percentage of HIV+ clients who have evidence of a primary care visit being completed within 91 days of release from incarceration to 80% of those released .

#2 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients. Indicator: Increase in the percentage of clients retained in care (defined as having two or more HIV medical visits at least 3 months apart in the measurement year) to 80% of clients served and enrolled for most or all of the measurement year.

Service Category: Legal Services				**Planning Council Allocation:**	**$3,818,827**
Service Priority: 11				**Part A Support**	
Service Goal: Facilitate access to HIV related primary care services and appropriate support services by legal advocacy to remove barriers to care				**Comprehensive Plan: Goal 4: Reduce HIV/AIDS health disparities.**	
1. Objectives:	**2. Service Unit Definition:**	**3. Quantity**		**4. Time Frame:**	**5. Expenditures:**
		3a) Number of People	**3b) Number of Service Units**		
a. Provide interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality, and assist with permanency planning for dependents of an adult expected to pre-decease them due to HIV/AIDS.	One legal advocacy visit	3,165	28,309	3/1/13 - 2/28/14	4,086,567

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Facilitating access to HIV primary care, for those HIV+ clients out of care at the time of entry into legal services. Indicator: Increase in the percentage of HIV+ clients without HIV primary care for over 6 months who are successfully linked to care to 60% of those out of care at start of services and receiving legal services for at least one month.

#2 Outcome: Retaining HIV+ legal services clients in HIV primary care. Indicator: Increase in the percentage of legal services clients who are remaining in HIV/AIDS medical care to 75% of clients served and enrolled for most or all of the measurement year.

Service Category: Psychosocial Support Services				Planning Council Allocation:	$1,880,463
Service Priority: 10				Part A Support	
Service Goal: To provide access to supportive counseling and information to PLWHA and their families				Reference Comprehensive Plan: Goal 3: Promote optimal management of HIV infection.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Provide supportive counseling and family stabilization services to clients.	One supportive counseling visit	980	8,598	3/1/13 - 2/28/14	2,139,740

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Facilitating access to HIV primary care, for those HIV+ clients out of care at the time of entry into psychosocial support services. Indicator: Increase in the percentage of HIV+ clients without HIV primary care for over 6 months who are successfully linked to care to 70% of those out of care at start of services and receiving psychosocial support services for at least one month.

#2 Outcome: Retaining HIV+ psychosocial support services clients in HIV primary care. Indicator: Increase in the percentage of psychosocial support services clients who are remaining in HIV/AIDS medical care to 85% of clients served and enrolled for most or all of the measurement year.

Service Category: Health Education/Risk Reduction				Planning Council Allocation:	$394,350
Service Priority: 12				Part A Support	
Service Goal: To improve treatment outcomes (viral load, CD4) among workshop participants				Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 3: Promote optimal management of HIV infection.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Improve knowledge on care engagement, treatment adherence, and risk behavior among PLWHA.	One individual attending a self-management workshop (multi or single-day)	453	34	3/1/13 - 2/28/14	375,972

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Improving self-reported attitudes around patient-provider relationships. Indicator: Statistically significant improvement in scores from pre-test to post-test on 3 items from the Patient Self-Advocacy Scale.

#2 Outcome: Improving ART treatment adherence as measured by self-reported ART treatment adherence. Indicator: Statistically significant improvement in scores on ART treatment adherence items from pre-test to a 3-month follow-up assessment point.

Service Category: Medical Transportation Services				Planning Council Allocation:	$75,588
Service Priority: 15				Part A Support	
Service Goal: To increase access to care and services through provision of transportation services to PLWHA in need of transportation services to maintain engagement in HIV services.				Comprehensive Plan: Goal 3: Promote optimal management of HIV infection.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Provide transportation services to PLWHA in the Tri-County Region to ensure access to HIV health care services.	One ride to medical appointment and/or social service appointment	390	9,838	3/1/13 - 2/28/14	334,000

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Ensuring that mobility-impaired PLWHA clients have regularly available transportation to their health and social service destinations. Indicator: Increase in the percentage of HIV+ clients receiving at least one transportation service in a six-month period to 75% of HIV+ clients enrolled in transportation services for at least six months.

#2 Outcome: Monitoring and ensuring regular engagement in primary medical care for medical transportation services clients. Indicator: Increase in the percentage of medical transportation services clients who are remaining in HIV/AIDS medical care to 85% of clients served and enrolled for most or all of the measurement year..

Grantee: New York EMA - H89HA00015

FY2013 Minority AIDS Initiative Implementation Plan

MAI Award (including carryover): $ 9,760,126

MAI Programs (including carryover): $ 8,818,883

Service Category: Outpatient/Ambulatory Health Services			Planning Council Allocation:		$1,250,304
Service Priority Number: 2			MAI Core Medical		
Service Goal: Improve health outcomes of PLWHA.			Reference Comprehensive Plan: Goal 3: Promote optimal management of HIV infection.		
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
b. Increase access to HIV primary and specialty care in various clinical settings by reimbursing service providers through the NYS HIV Uninsured Care Program.	One medical visit claim reimbursed by NYS HIV Uninsured Care Program - ADAP Plus	1,083	12,404	3/1/13 - 2/28/14	1,654,115

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients. Indicator: Increase in the percentage of clients retained in care (defined as having two or more HIV medical visits at least 3 months apart in the measurement year) to 80% of clients served and enrolled for most or all of the measurement year.

#2 Outcome: Slowing/preventing disease progression in HIV+ clients. Indicator: Increase in the percentage of clients with improved or stable CD4 counts to 85% of clients with 2 or more CD4 counts during the measurement year.

Service Category: Medical Case Management (including Treatment Adherence)			Planning Council Allocation:		$4,453,115
Service Priority Number: 5			MAI Core Medical		
Service Goal: Ensure that PLWHA are promptly linked to medical services at time of diagnosis and are provided with all support needed to access lifelong, regular health care. Reduce premature and excess morbidity and mortality by ensuring engagement in primary care and other HIV related care.			Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 3: Promote optimal management of HIV infection. Goal 4: Reduce HIV/AIDS health disparities.		
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Ensure that PLWHAs are assisted with linkage to and maintenance in primary medical care.	One appointment for intake, medical, and social service need assessment, treatment planning or follow-up	1,085	34,268	3/1/13 - 2/28/14	$ 3,671,851
	Linkage to primary care for homeless individuals	49	49	3/1/13 - 2/28/14	$ 6,015
b. Support delivery of primary care to enrolled PLWHA by facilitating adherence to scheduled appointments.	One accompaniment to appointment by patient navigator	234	624	3/1/13 - 2/28/14	$ 76,603
c. Provide individualized health promotion and adherence support including interdisciplinary medication management support.	One treatment adherence education, coaching, health promotion and/or Directly Observed Therapy visit	341	8,258	3/1/13 - 2/28/14	$ 681,273

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Monitoring and ensuring regular engagement in primary medical care for HIV+ clients. Indicator: Increase in the percentage of clients retained in care (defined as having two or more HIV medical visits at least 3 months apart in the measurement year) to 80% of clients served and enrolled for most or all of the measurement year.

#2 Outcome: Achieving and maintaining optimal ARV treatment adherence among those on ARVs. Indicator: Among clients receiving antiretroviral (ARV) medications, an increase in the percentage of clients who adhere to their prescribed medication regimen, to 80% of those with four months or more of treatment adherence intervention.

Service Category: Early Intervention Services				Planning Council Allocation:	$1,715,747
Service Priority Number: 9				MAI Core Medical	
Service Goal: Reduce the number of HIV+ individuals unaware of their status, and reduce HIV related morbidity and mortality by effectively linking clients to and engaging clients in medical care.				Comprehensive Plan: Goal 1: Increase individuals who are aware of their HIV status. Goal 2: Promote early entry into HIV care.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Provide outreach and HIV testing to clients who are unaware of their status, and effectively link to HIV primary care both those individuals who test positive and those who are known to be HIV+ but not in care.	One successful outreach with HIV test performed or referral made	16,393	17,400	3/1/13 - 2/28/14	1,644,271
	One linkage to medical care	113	113	3/1/13 - 2/28/14	10,678

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Increasing awareness (diagnosis and notification/counseling) of positive HIV status among those infected. Indicator: Increase in the percentage of PLWH who know their HIV status (measured as receipt of diagnosis) to 70% of those with new confirmatory positive test results during the measurement year.

#2 Outcome: Facilitating access to and engagement in HIV medical care among the newly diagnosed and those previously diagnosed but out of HIV/AIDS medical care. Indicator: Among PLWH who know their status, an increase in the percentage successfully linked to HIV/AIDS medical care to 80%.

Service Category: Housing Services				Planning Council Allocation:	$1,052,027
Service Priority Number: 6				MAI Support Service	
Service Goal: Reduce homelessness, and improve housing access for PLWHA. Reduce HIV-related morbidity for homeless or unstably housed PLWHA. Increase access and engagement in medical care for target population.				Comprehensive Plan: Goal 2: Promote early entry into HIV care. Goal 4: Reduce HIV/AIDS health disparities.	
1. Objectives:	2. Service Unit Definition:	3. Quantity		4. Time Frame:	5. Expenditures:
		3a) Number of People	3b) Number of Service Units		
a. Provide housing placement assistance and transitional housing for PLWHA who are unstably housed, homeless and in targeted communities so that they can access and remain engaged in HIV primary care.	One transitional housing placement	20	20	3/1/13 - 2/28/14	356,136
b. Placement in permanent housing for those individuals who request it.	One permanent housing placement	29	40	3/1/13 - 2/28/14	712,272

6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:

#1 Outcome: Increasing access to and maintenance of stable housing. Indicator: Increase in the percentage of HIV+ clients in housing services who achieve a stable housing situation as of last assessment to 65% of those re-assessed for housing status during the measurement year and receiving at least six months of housing services prior to that re-assessment.

#2 Outcome: Retaining HIV+ housing services clients in HIV primary care. Indicator: Increase in the percentage of housing services clients who are remaining in HIV/AIDS medical care to 75% of clients served and enrolled for most or all of the measurement year.